BLINDED VETERANS ASSOCIATION

TESTIMONY
PRESENTED BY

THOMAS ZAMPIERI, Ph.D.
DIRECTOR OF GOVERNMENT RELATIONS

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Introduction

Mr. Chairman and members of the House Veterans Affairs Subcommittee on Health, on behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to present BVA's legislative concerns on the topic "Poly Trauma Center Care and the TBI Patient: How Seamless is the Transition Between VA and DoD and Are Needs Being Met?" BVA is the only Congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. This past year BVA has developed increasing concern over improving VHA's ability to provide the full continuum of both inpatient and outpatient rehabilitative service programs and to increase resources to be commensurate with the growing numbers of wounded and injured entering the VA health care and benefits system from Department of Defense (DoD) care. The issue of Traumatic Brain Injury (TBI) is of paramount concern to BVA. We appreciated this hearing as a step in working together on improving the system.

Types and Causes of TBI

Last year, articles appeared and DoD reported that more than 11,852 returning wounded had been exposed to blast injuries, the most common being from IEDs. This is an astounding number when one considers that as of March 8, 2007, there was a reported 23,417 traumatic combat injuries. TBI has become the "signature injury" of Operation Iraq Freedom (OIF) and Operation Enduring Freedom (OEF) operations.

As BVA reported in our previous testimony on September 20, 2006, blast-related injury is now the most common cause of trauma in Iraq. One study found that 88 percent of the military troops treated at an Echelon II medical unit in Iraq were from IED blasts. Of those, 47 percent suffered TBI injuries. Data from the screening of 7,909 Marines with the 1st Marine Division showed that 10 percent of them suffered from TBI-related injuries ten months after returning from Iraq. At Fort Irwin, 1,490 soldiers were screened last May with almost 12 percent of them having suffered concussions resulting in mild to moderate TBI injuries.

One statistic frequently overlooked and reported by the Iraq Coalition Casualty Count website is that of the men and women wounded, only 7,005 have required Aeromedical evacuation. A reported 6,835 non-hostile injured required Aeromedical transportation. As in the history of many previous conflicts and wars in our history, more service members (18,704) have been evacuated by air from Iraq due to medical diseases. The reason BVA points to this data is that a large percentage of those wounded and injured in Iraq (16,412) are Returned to Duty (RTD). These troops usually complete the full tour in Iraq before redeploying back to the base of departure. Those mild to moderately TBI-injured are, therefore, at very high risk of not being screened for complications of TBI upon return. The previous data outlined in this section were only random screenings done. They were not mandated by DoD and, according to the article detailing this issue, there is actual resistance to any standardized screening programs of all service members who have sustained mild to moderate TBI-type concussions.

More than 1,882 of the total moderate to severe TBI-injured tracked from January 2003 to January 2007, by the Defense and Veterans Brain Injury Center (DVBIC) have sustained

moderate enough TBI to result in neurosensory complications. Epidemiological TBI studies have found that about 30 percent of the injured have associated visual disorders of diplopia, convergence disorder, photophobia, ocular-motor dysfunction, and the inability to interpret print. Some TBIs have resulted in legal blindness and other manifestations known as **Post-Trauma Vision Syndrome** (PTVS). BVA applauds the efforts of the Defense and Veterans Brain Injury Center (DVBIC), which has worked hard to develop an extensive, multidisciplinary TBI team that will test all of the wounded arriving at both Walter Reed Army Medical Center and the National Naval Medical Center where reportedly 28% of all wounded have sustained TBI. We support these efforts but also call attention to the need for additional funding and resources to continue the collaborative efforts of this ongoing program between DoD and several VA medical treatment facilities.

As most members of this Committee know, a study in early 2006 by researchers at Harvard and Columbia revealed that the cost of medical treatment for service members with TBI would be at least $14 billion over the next 20 years. This is a conservative estimate. The now famous Linda Bilmes' "Long Term Costs of Providing Veterans Medical Care and Disability Benefits," published by Harvard on January 5, 2007, states the following: "The budgetary costs of providing disability compensation benefits and medical care to the veterans from Iraq and Afghanistan over the course of their lives will be $350 - $700 billion, depending on the length of deployment of US soldiers, the speed with which they claim disability benefits, and the growth rate of benefits and health care inflation."

While some argue over the exact numbers utilized for the aforementioned report, it is clear that additional wounded are being added to the counts each week. After factoring in lost wages of the TBI service member, family caregivers, various VBA benefits, long-term disability and health care costs, specialized prosthetics and adaptive equipment, various other state and other federal support programs involved in providing services, BVA argues vehemently that these figures are probably an accurate starting point for cost estimates for the wounded—medical complications and mental health problems—from OIF and OEF operations.

BVA emphasizes once again to this Committee that, in addition to the above concerns, data compiled between March 2003 and April 2005 found that **16 percent of all causalities evacuated** from Iraq had direct eye injuries. Walter Reed Army Medical Center has surgically treated approximately 700 soldiers with either blindness or moderate-to-severe significant visual injuries. The National Naval Medical Center has a list of more than 450 eye injuries that have required surgery. VA reports that although 42 of these service members have attended one of the ten VA Blind Rehabilitation Centers, 88 are enrolled in local VA Blind VIST Services. Others are in the process of being referred. It should be obvious to members of this Committee that a new generation of visually impaired, low-vision, or legally blinded veterans with PTVS and complex neurological injuries will require a lifetime of specialized services. TBI veterans (and their family members) injured in blasts will require individualized rehabilitation programs that could utilize the expertise from the wide variety of currently available federal, state, and community resources.

Risks and Complications of Undiagnosed TBI

The lack of effective screening programs, coupled with inaccurate diagnosis and treatment of TBI and its associated PTVS conditions, may impair veterans' ability to perform basic activities of daily living. If early detection and treatment are not initiated, further consequences include increased unemployment, failure to succeed in educational programs pursuits, greater dependence on government assistance programs, depression and other psychosocial complications, and homelessness. The effects of TBI on the veteran may be extended to family members. It is well known that TBI causes intense stresses in family and interpersonal relationships. All policy plans should incorporate strong family support programs

Neurological Impact of Post-Traumatic Vision Syndrome

Perception plays a significant role in the way in which one approaches life. Perception aids in providing information about the properties of one's environment. It also allows one to act in relation to those properties. In other words, perceptions allow individuals to experience their environment and live within it. They perceive the composition of their environment by a filtered process that occurs through a complex neurological visual system. Although all senses play a significant role, the visual system is one of the most important.

With various degrees of visual loss, the visually impaired are no longer able to clearly adjust and see their environment, resulting in increased risk of injuries, loss of functional ability, and employment. Impairments range from losses in the visual field and visual acuity to loss of color vision and the ability to recognize faces. There are numerous ways in which one can acquire visual deficits. One leading cause is injury to the brain. Damaging various parts of the brain can lead to specific visual deficits. Although some cases have reported spontaneous recovery, complete recovery is unlikely unless there is early intervention. Current complex neuron-visual research is being conducted in an attempt to improve the likelihood of recovery when there is long-term follow up with specialized adaptive devices and prescriptive equipment.

The brain is the most intricate organ in the human body. One of the greatest complexities of the brain involves the visual pathways within its structure. Due to the interconnections between the brain and the visual system, damage to the brain can bring about various cerebral/visual disorders. The visual cortex has its own specialized organization, causing the likelihood of specific visual disorders if it is damaged. The occipitotemporal area is connected to the "what" pathway. Thus, injury to this ventral pathway leading to the temporal area of the brain is assumed to affect the processing of shape and color. This can make the perception and identification of objects difficult. The occipitoparietal area (posterior portion of the head), is relative to the "where" or "action" pathway. Injury to this dorsal pathway leading to the parietal lobe will increase the likelihood of difficulties in position (depth perception) and/or spatial relationships. In cases of injury, one will find it hard to determine an object's location due to impaired visual navigation. In addition, it is highly unlikely that a person with TBI will have only one visual deficit. There is usually a combination of deficits due to the complexity of organization between the visual pathway and the brain. The most common cerebral/visual disorder following brain injury involves visual field loss. The loss of peripheral vision can be

sufficiently severe as to result in legal blindness, requiring specific visual field testing to correctly diagnose the loss and to prescribe the devices to adapt to it.

Current and Future Programs for Comprehensive Services

BVA recommends an immediate and timely implementation of the full continuum of outpatient services for all visually impaired veterans through the following programs: Blind Rehabilitation Outpatient Specialists (BROS), Visual Impairment Center To Optimize Remaining Sight (VICTORS, which is a specialized low-vision optometry program), and the Visual Impairment Services Outpatient Rehabilitation Program (VISOR). Implementing Secretary Nicholson's directive of January 2007 could assist in the early screening for neurological complications affecting the vision of service members and veterans with a high risk or history of TBI.

Visual Impairment Services Outpatient Rehabilitation (VISOR)

VISOR is a highly successful outpatient nine-day rehabilitation program. It offers screening, skills training, orientation and mobility, and low-vision therapy. The approach combines the features of a residential program with those of outpatient service delivery. A VIST Coordinator with credentials in the low-vision field manages the program staff, which consists of a certified BROS trained in Orientation and Mobility. Rehabilitation Teachers and Low-Vision Therapists are also essential components of the teams. VHA has approved central funding for three years to establish a VISOR program in each network. We therefore request that Congress provide the funding to ensure delivery of this service. Because new programs often face internal fierce budget competition and planned program sections are often cut or delayed, we ask for $16.5 million for three years to ensure that VISOR can be fully implemented.

Visual Impairment Center to Optimize Remaining Sight (VICTORS*)*

Another important model of service delivery that does not fall under VA Blind Rehabilitation Service is VICTORS, an innovative program operated by VA Optometry Service. VICTORS has been successful for more than 15 years. This special low-vision program is designed to provide low-vision services to veterans, who, although not legally blind, suffer from some degree of visual impairment. Veterans must generally have a visual acuity of 20 over 70 or less to be considered for this service.

VICTORS typically involves a short (five-day) outpatient program in which the veteran undergoes a comprehensive, low-vision evaluation. VICTORS can be established in any VA Medical Center outpatient eye clinic area. The low-vision optometrists found in VICTORS programs are have the specialized skills necessary for assessing, diagnosing, treating, and managing the cases service members with TBI or other aforementioned low-vision injuries. The Palo Alto VA Poly Trauma Center and Eye Clinic has already initiated the screening of TBI veterans, reporting that 20 percent of all admissions had some form of PTVS that required adaptive devices and technology.

VHA plans at least eight new VICTORS programs during FY 2007-2008. All should be fully implemented by the end of that time frame. BVA strongly supports current VHA plans to increase the number of part-time, Low-Vision Optometrists and Low-Vision Ophthalmologists in the new VISOR and VICTORS programs. VISOR and VICTORS are high-quality, cost-effective outpatient programs that screen, diagnosis, treat, the expanding TBI population. The programs also conduct effective follow-up after treatment. We reiterate our appreciation that new services are being funded from existing accounts within VHA over the next three years but would urge Congress to appropriate the necessary $16.5 million each year to support the full implementation of these most vital services for blind and visually impaired veterans.

Vision Rehabilitation Needs at VA/DOD Facilities

To better meet the current Traumatic Brain Injury/Low Vision rehabilitation demands, increased access to specialty care at both DoD and VHA Poly Trauma medical facilities is a must. Such access requires a team of vision rehabilitation providers that includes TBI/Low-Vision Rehabilitation Trained Optometrists, Neuro-Ophthalmologists, Low-Vision Therapists, and Blind Rehabilitation Outpatient Specialists located at each DoD TBI and VHA Polytrauma Rehabilitation Network site. These highly specialized eye care providers will require education, training, and consultation from TBI vision rehabilitation experts in universities with the appropriate experience so that they can appropriately diagnose, treat, and provide high-quality vision rehabilitation services

Electronic Health Records

BVA is very concerned about the growing backlog caused by the lack of substantial progress in the exchange of health care records. We believe that DoD and VA must speed up the development of electronic medical records that are interoperable and bi-directional, allowing for a two-way electronic exchange of health information and occupational/environmental exposure data. Our military personnel are still in theaters of operation and the numbers of wounded grow each week, but the continued delays in getting complete medical, surgical, and diagnostic records to VHA and VBA are inexcusable. The joint electronic medical records should include an easily transferable electronic DD214 forwarded from DoD to VA. This would allow VA to expedite the claims process and give the service member faster access to health care and other critical benefits. The Armed Services Committees and VA Committees should set clear benchmarks for full implementation. They should then budget accordingly.

State Programs and Additional Federal Programs

Current estimates reveal that at least 5.3 million Americans require long-term or lifelong assistance in performing activities of daily living as a result of TBI. Each year 50,000 Americans die, 235,000 are hospitalized, and 1.1 million visit emergency rooms from such injuries. The estimated total cost, both direct and indirect, of such injuries is in the neighborhood of $56.3

billion. The problems that confront us today, therefore, are not new to other state and federal agencies that have tried to deal with them in the past.

Individuals who have suffered TBI, along with their families, are often faced with the challenge of improper diagnosis, an inability to access support or rehabilitation services, institutional segregation, unemployment, and the daunting task of navigating complicated multiple layers of county, state, and federal agency services. TBI patients and their families face even greater challenges in rural regions of the country where specialized services are sorely lacking. Returning service members are not immune to these challenges as DoD reports that 20 percent of the wounded are from communities with a population less than 20,000.

Recognizing the large number of individuals and families struggling to access appropriate and community-based services, Congress authorized the Federal TBI Program in the TBI Act of 1996 (PL 104-166). The TBI Act of 1996 launched an effort to conduct expanded studies and to establish innovative programs for TBI. It gave the Health Resources and Services Administration (HRSA) authority to establish a grant program for states to assist HRSA in addressing the needs of individuals with TBI and their families. It also delegated responsibilities in the areas of research, prevention, and surveillance to the National Institutes of Health and the Centers for Disease Control and Prevention.

Title XIII of the Children's Health Act of 2000 (PL 106-310) reauthorized the programs of the TBI Act of 1996. The TBI Act reauthorization also recognized the importance of Protection and Advocacy (P&A) services for individuals with TBI and their families by authorizing HRSA to make grants to state P&A systems. The HRSA Maternal and Child Health Bureau administers the federal TBI Program. From an original appropriation of $8,910,000, the final FY 2006 allocation for the TBI Program was $8,467,448. This year, as well as in recent previous years, key Members of Congress supportive of this meager funding have had to fight for even small appropriations. In view of the statistics presented in this testimony, we fully support the requested $15 million recommended for HRSA TBI State Grants Program, and Center for Disease Control and Prevention (CDC) TBI Surveillance, Registries, Prevention and National Education/Public Awareness $ 9 million in FY 2008 and ask for your support.

Traumatic Brain Injury Technical Assistance Center (TAC)

The Federal TBI Program supports a TBI TAC at the National Association of State Head Injury Administrators. The TBI TAC was established to help states in the planning and development of effective programs that improve access to health and other services for individuals with TBI and their families. TBI TAC staff specialists provide states with individualized technical assistance. Additionally, the TBI TAC develops and disseminates a variety of specialized documents and initiatives for the federal TBI Program. For example, TBI TAC has developed a set of benchmarks that can be used by grantees to assess their progress in meeting program goals and objectives. The TBI TAC is also developing outcome measures that the program will be able to use to better assess the impact of TBI state and Protection and Advocacy grants on people-centered services and sustainable systems change.

Collaboration

BVA believes that the federal TBI TAC program should become a partner with DoD and VA leadership in the coordination of existing programs, thus bringing about a more multidisciplinary approach. The program already provides for the collaboration and communication between various governmental, professional, and private organizations representing leaders and policymakers concerned with TBI-related issues. On February 12, 2007, VA Secretary Nicholson announced that VA would begin partnering with the National Association of State Directors of Veterans Affairs (NASDVA) to improve communication and coordination of services. It would seem that this new effort in Seamless Transition should incorporate the Federal TBI TAC program experience. Doing so would greatly benefit veterans and all Americans with TBI as they receive people-centered services and best practices learned from a variety of ongoing research activities.

Oversight

The oversight priority should be to ensure that VHA has the ability to provide the full scope of preventative and acute rehabilitation care services. The expansion of these TBI specialized services provided by VHA are critical now to meet the demands from OIF and OEF injuries, to maximize independence, and to prevent costly misdiagnosis. These critical Low Vision and Blind outpatient programs must be fully funded as outlined since they can provide urgently needed screening, treatment, and follow-up services. Mr. Chairman, the fact that the milder to moderate TBI injury cases are not being screened at many DoD bases is not acceptable. Members of this Committee should work with other members of Congress to correct this deficiency. Under the model we propose, the objective is to develop TBI patient and family-centered measurements of individual functional abilities and then determine how those abilities can be maximized through various rehabilitative, vocational, educational, and employment services among DoD and VA. Resources are infused into federal, state, and local programs to ensure that such programs provide accessible treatment, rehabilitation, and continued follow-up services.

Conclusions

Mr. Chairman, thank you for this opportunity to submit our testimony for the record. BVA is extremely concerned that TBI-injured veterans and family members from OIF, OEF, and previous wars are not able to access the full continuum of services discussed here today. The future strength of our Nation depends on the willingness of young men and women to serve in our military, and that willingness depends in part on the willingness of our government to meet its full obligation to them as veterans. Waiting will only increase the problems and expenses associated with this growing policy problem. This complex health care issue has probably been one that long ago should have received more emphasis and attention. Only when the recent media spotlight forced it to the top of the agenda did it seem to rise to the radar screen for most Americans. More research, screening, treatment, and family support must occur. Improvements

in rehabilitative outpatient services and increased public awareness of such available services are a must.

Recommendations

1. Authorize the $300 million in additional funding for the development of designated TBI/VA Poly Trauma Centers to provide veterans with comprehensive specialized inpatient and outpatient rehabilitative services; ensure accreditation of these specialized programs; provide educational funding for staffing; expand vocational and educational programs for veterans with TBI; support caregiver programs with family support counseling; improve case management; and develop best practices.

2. Support an increase of $19.5 million for the Defense and Veterans Brain Injury Center in the Defense authorization for FY 2008. BVA believes that Congress should ensure high quality ongoing screening of those at risk of TBI by their previous exposure history. DoD and VA primary clinical medical staff should be educated on the identification, history, diagnosis, and appropriate consultation management of the TBI service member.

3. The federal TBI TAC Program should partner with DoD and VA. The program already partners with other federal representatives in the coordination of existing regulations, funding, and services to best meet the needs of our veterans and their family members. Such partnerships provide for effective collaboration and communication among various governmental, professional, and private organizations representing leaders and policymakers concerned with TBI-related issues.

4. Congress must mandate with specified time benchmarks a single, bi-directional, electronic health care record system for a truly efficient Seamless Transition. DoD and VA must implement a mandatory single separation physical examination, including a copy of DD 214, as a prerequisite to prompt completion of the military separation process. They should suggest a pilot joint DoD/VA medical and benefits transition service in which the severely injured and their families would have both DoD and VA benefits teams at these major medical treatment facilities.

5. To better meet the current Traumatic Brain Injury/Low Vision rehabilitation demands, access to this specialty care needs to be improved. This requires a team of vision rehabilitation providers that includes TBI-Low Vision rehabilitation-trained optometrists, Low Vision Therapists, and BROS at each Lead TBI and VHA Polytrauma Rehabilitation Network Site. These eye care providers will require education and training from TBI-vision rehabilitation experts. Because VA has reduced clinical continuing education funding for many non-physician occupations, BVA urges increased budgeting and oversight on this type of care by the Committee members.

6. Develop an accurate TBI registry of individuals with mild, moderate, and all severe head injuries; increase the ability to provide excellent vision rehabilitation care to optimize outcomes for patients with TBI; and incorporate clinical research to document findings,

analyze data, and publish results so that TBI/Low Vision rehabilitation of OIF/OEF veterans may continually improve.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS
Blinded Veterans Association

The Blinded Veterans Association (BVA) does not currently receive any money from a federal contract or grant. During the past two years, BVA has not entered into any federal contracts or grants for any federal services or governmental programs.

BVA is a 501c(3) congressionally chartered, nonprofit membership organization.

THOMAS ZAMPIERI BIOGRAPHY

Thomas Zampieri is a graduate of the Hahnemann Univeristy Physician Assistant Program (June 1978). He obtained a Bachelor of Science degree from State University of New York and graduated with a Masters Degree in Political Science from the University of St. Thomas in Houston, Texas, in May 2003. Mr. Zampieri completed his Political Science Ph.D. degree at Lacrosse University in January 2006.

He has been employed since April 2005 as the National Director of Government Relations for the Blinded Veterans Association, a Congressionally chartered Veterans Service Organization founded in 1945.

Mr. Zampieri served on active duty as a Medic in the U.S. Army from 1972 to 1975. Upon completing Physician Assistant training, he served from September 1978 to August 2000 as an Army National Guard Physician Assistant, retiring as a Major. During this time, he was involved in several military medical training programs and schools, successfully completing the Army Flight Surgeon Aeromedical Course at Fort Rucker in 1989 and the U.S. Army Medical Department’s Advanced Officer Course at Fort Sam Houston, Texas, in 1992.